

APPENDIX CMH-1**Notice of Eligibility and Referral for
Illinois Children's Mental Health
Screening, Assessment and Support Services**

Date of Notice:

Effective _____, the child or teenager named below is eligible for mental health Screening, Assessment and Support Services (SASS). This SASS mental health coverage will end at midnight on _____.

Keep this notice. You may need to show it to get services for your child.

Name	Date of Birth	Recipient ID Number
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The SASS agency named below will assess your child's need for mental health services.

This agency will decide whether your child can receive mental health services in the community. If a doctor decides your child needs to be admitted to a hospital, the agency will work with the hospital to plan for services in the community after discharge. The agency will provide or arrange for all of your child's SASS mental health services. The agency will coordinate your child's care. It is important that you work closely with the agency.

Your child's mental health services have to be approved ahead of time. Talk to your SASS agency about the treatment plan. Covered services may include community mental health services and transportation to and from a clinic, doctor's office or hospital for treatment. Your child may also be covered for certain medications, crisis intervention, assessment and planning as well as treatment.

You have the right to choose providers to treat your child. If you want the state of Illinois to pay for your child's treatment, you must choose a provider that is enrolled in this program. Talk to your SASS agency about available providers.

If your child has a mental health emergency and needs help right away, call your SASS case manager at _____. Persons using a TTY can call _____.

Notice to Providers: To verify eligibility for the person named above, use the MEDI internet system at <http://www.myidpa.com>, your REV vendor or IDPA's Automated Voice Response System (AVRS).

APPENDIX CMH-2

FAMILY RESOURCE DEVELOPER (FRD) JOB DESCRIPTION MENU

Current emerging research recognizes the benefits to consumer families of direct contact with a FRD as part of the care team. The position should be an effective resource for peer/consumer information and support for SASS children. The FRD should also serve as an efficient channel for consumer feedback to the SASS provider. The following guidelines have been developed to assist SASS programs for using the positions as intended.

Selections 1 and 2 highlight qualifications and competencies to be considered in hiring for the position. Section 3 discusses responsibilities of the SASS provider in relation to the FRD position. Sections 4,5,6 and 7 present a MENU of options from which the individual job description can be assembled as per the needs of the SASS children and community.

SECTION 1 FRD - Qualifications

- FRD must be a parent or caregiver who has navigated multiple child serving systems on behalf of a child or adolescent with Severe Emotional Disturbance (SED) as a consumer of the mental health system.
- FRD must have, at a minimum, a high school diploma or equivalency.
- FRD must have a valid drivers license, access to a fully insured motor vehicle, proof of insurance, and meet the employers driving record criteria.
- FRD must pass a state of Illinois background check, as required by employing SASS provider.

SECTION 2 FRD - Competencies

Ability to demonstrate the following:

- To work collaboratively as a member of a team that includes families, children, SASS provider staff and other providers in the community.
- To communicate effectively in both written and verbal formats.
- To demonstrate sensitivity to the impact of ethnicity, race, culture, economic differences, sexual orientation, differing lifestyles, religious background, and individualized family values as they impact upon consumers of service.
- To organize work activities and maintain records.
- To utilize reporting procedures as directed by the SASS provider.
- To be resourceful and knowledgeable about community resources.
- To show initiative and be self motivated in the position of FRD.
- To show good judgment in discharging the responsibilities of the position and in advocating for the best interests of children.
- To learn, understand, and adhere to the SASS provider's policies, procedures, structure and table of organization.
- To understand the SASS provider's mission, vision and values, and be able to impart them.
- To prioritize activities in collaboration with the supervisor.
- To know when to ask for help.
- To navigate multiple systems of care i.e., education, mental health, juvenile justice, health care, Department of Child and Family Services, etc.
- To have effective interpersonal skills.

SECTION 3 SASS Provider's Responsibilities to FRD Position

- Commitment from SASS Provider's executive director, board of directors and staff to support the FRD position.
- Prepare the SASS provider's culture to accept, support and integrate the role of the FRD.
- Provide orientation to SASS provider's context: How the FRD position relates to other programs and overall SASS provider's organization.
- Provide training for all job responsibilities, i.e., mental illness, parents' rights, youth's rights, documentation, reporting, confidentiality, mandated training, abuse and neglect issue.

- Provide a designated person who acts in the role of supervisor, and who holds regularly scheduled meetings with the FRD to discuss position activities.
- Provide the FRD with resources and support services as required to fulfill the responsibilities of the position, i.e., equipment for communication: computers, phones, fax machines, pagers, as well as, copier availability and clerical support.
- Provide flexible benefits to support a parent or caregiver of a child with SED, in the position of FRD in accord with SASS provider's policies i.e., vacation, holidays, personal days, flexible hours, insurance benefits, relief time for emergencies, sick time, medical leave, etc.
- Reimbursement for business expenses consistent with the employers policies and procedures i.e., travel time, mileage, tolls, parking per diem rate, hotels, telephone expenses, copies and travel.
- Allow portions of time for job related training and travel.
- Include the FRD in staff development activities and training.
- Provide the FRD with a formal evaluation of their work on a time schedule consistent with the employment policy of the SASS provider.
- Include the FRD in discussions and decisions about SASS services, policy, design of services, an advisory council, committees, etc.

SECTION 4 FRD - Parent Support Functions

- Provide information and link families to community resources.
- Participate in the orientation of new child's families to SASS services.
- Attend meetings with family members, in coordination with fellow team members, to advocate for and assist in the application for other services i.e., court proceeding, school staffings, public aid etc.
- Maintain resource directory for the geographical area serviced by the SASS provider.
- Work with SASS provider to ensure family involvement in all aspects of services.
- Assist clinicians in identifying strengths and needs of the families.
- Increase engagement in care by assisting families in moving through the SASS provider intake process.
- Assist families in transition to other levels of service.
- Participate in the hospital discharge process by assisting with the development of sufficient parent support to enable follow through with the discharge plan.
- Be available to parents or caregivers via phone, pager or in person within SASS providers agreed upon time limits/assignment.
- Support consumer rights.
- Empower parents and families to make their own informed decisions about all aspects of services.
- Assist consumers in understanding, seeking and achieving the best possible outcomes for their child, including complete recovery.
- Attend SASS provider multi-disciplinary staffings when requested by the family or staff, in compliance with confidentiality restrictions.

SECTION 5 FRD - Education/Training Responsibilities

- Assist in increasing families' knowledge and understanding of what to expect when a child/family is involved with SASS services.
- Educate families regarding natural supports and community resources.
- Provide technical assistance and training for professional staff regarding family involvement.
- Give presentations to parents and professional groups as needed.
- Coordinate a space within the SASS provider where parents can access resources and information regarding mental health i.e., Internet access, reading material, videotapes, self-help association information, handouts on diagnosis and medication.
- Recruit and educate parents to be advocates for children's mental health.
- Organize and conduct educational presentations on family consumer issues for other community agencies i.e., schools, churches, community groups, etc.
- Provide information on linkage to parent organizations and supports.
- Provide consumer information on parent and youth rights and responsibilities.
- Participate with the SASS provider in policy development and implementation regarding changes in policies and procedures related to consumer/family needs.
- Conduct parent orientation to system of care, i.e., services, programs, etc.

SECTION 6 FRD - Program Evaluation Functions

- Recruit parents to involve them in evaluation, planning and implementation of services.
- Participate in the development, implementation, and evaluation of SASS services including such functions as: conducting focus groups, implementing consumer surveys, analyzing feedback received and formulating quality improvement plans.

SECTION 7 FRD - Meeting Attendance**Required:**

Participate, as a member, in meetings, groups, or committees such as:

- Individual consultation with the supervisor
- A monthly FRD peer networking group
- SASS provider child and family centered consumer meetings

Suggested:

Participate, as a member, in meetings, groups or committees such as:

- Quarterly meeting with the executive director,
- DHS or DCFS consumer oriented meetings or advisory councils as indicated by the Departments,
- SASS provider quality assurance meetings,
- Relevant committee meetings.

APPENDIX CMH-3

INDIVIDUAL CARE GRANT PROGRAM SASS ICG SUPPORT PROTOCOL

ICG Facts

- The ICG program has received approximately 1,000 requests for applications per year over the past 3 years. Less than 1/3 of these requested applications are returned completed to the ICG program office.
- The ICG program funds approximately 450 severely emotionally disturbed children. ICG funding can be utilized for either residential treatment or intensive community based services.
- Approximately 24% of ICG recipients have successfully utilized ICG funding for intensive community based services.
- A “case management” pilot study conducted in fiscal years 2002 and 2003 showed that, of those children who utilized ICG funding for residential treatment the availability of an integrated community system decreased the amount of time spent in residential treatment and facilitated a coordinated transition home.

Since support and care coordination are key components of providing integrated services, DHS will implement a system that provides assistance to families at the time of the ICG application process, support while the ICG child is in residential care and support to the child utilizing intensive community based care. The SASS provider will serve as the administrative arm of the ICG program in the community and provide essential services to support ICG clients in short-term residential treatment, intensive community based care and during transition to a less restrictive level of care. In fiscal year 2005, DHS will reimburse SASS providers for the provision of comprehensive and coordinated care through the SASS support protocol and the SASS provider shall organize internal agency systems that are equipped to implement and carry out the protocol:

Application Assistance

Provide families with information that will help in the decision of applying for an Individual Care Grant.

Acquire and maintain knowledge about the Individual Care Grant program and Administrative Rule 135.

Assist families with the documentation compilation necessary to apply for an ICG.

Assist families in submitting a completed ICG application.

Reimbursement will be made upon submission of a completed application. Each completed application must be accompanied by a letter from the SASS provider with the child's name, Social Security number and date of completion.

It would be in the best interest of the SASS provider to facilitate timely receipt of the application.

Any application completed by a SASS provider that contains outdated material, or a completed application in which the child is ineligible due to age, (past the age of 17 years, 6 months) will not be reimbursable under this program.

Attend DHS/ICG training on ICG application process, protocol and rules.

Residential ICG Support

Acquire and maintain knowledge regarding the residential treatment facilities available to families.

Compile application packets for those families seeking residential services and assist with distribution to facilities.

Maintain ongoing facilitative relationships with families, schools and the child's community in order to support the service plan, including participation in the IEP meeting.

Provide no less than quarterly meetings with the family and residential case manager in person or by phone, if necessary.

Travel to the child's residential facility twice yearly if placed in Illinois, or an adjacent state (i.e. Indiana, Wisconsin). Travel once yearly if placed in any other state. During the visit attend staffing and advocate for child and family. Assess and recommend supports to facilitate treatment plan, facilitate transition to intensive community based services, when indicated.

Provide biannual reports to ICG program office as specified for ICG recipients utilizing residential services.

Assist parents/guardians with completing the forms and documentation necessary to support the ICG recipient (e.g., annual review documentation)

Maintain communication with the family, client, facility and ICG program office.

Provide staff to attend DHS/ICG training, or meetings specific to residential care.

Acquire and maintain knowledge about the Individual Care Grant program, Administrative Rule 135 and protocols.

Assist with the transition planning when an ICG recipient transitions out of the ICG program, to residential or to adult services.

Maintain documentation of the support services rendered and provide that documentation to the DHS/ICG program office upon request.

Intensive Community-based Support

Acquire and maintain knowledge regarding intensive community based services.

The SASS provider shall have comprehensive knowledge regarding multi disciplinary and multi-systems resources in the community.

The SASS provider shall offer the array of intensive community based ICG services, or have the ability to build and maintain relationships or alternate agreements with agencies or parties that can offer the array of community based ICG services.

These services include:

- Child Support Services
- Therapeutic Stabilization
- Behavior Management
- Young Adult Support Services

Complete an initial assessment with the child, family and other service providers such as school, residential and outpatient clinicians to develop a plan for services.

Maintain weekly communication with the family for the first month of community ICG services and at least monthly thereafter. Monitor satisfaction with the service provision. Assist the family with problem solving during the service delivery period.

Complete documentation necessary to obtain approval and authorization for community based ICG services.

- Initial Plan Development Form
- Initial Individual Services Plan- 30 days
- Cost Request Form
- Individual Service Plan – six-month report
- Diskette for Billing through ROC's system
- Annual Review Documentation

Assure that services provided through alternate arrangements follow the treatment plan and are provided as intended.

Coordinate and interface with the multiple providers involved with each ICG client so that the client receives comprehensive community based services.

Provide ongoing support functions to families regarding educational and other needs of the child, including advocating for the child within the school and support in the community. SASS should participate in IEP meetings.

Assist with the transition planning when an ICG recipient transitions out of the ICG program, to residential or to adult services.

Assist family with annual review documentation.

If a child is returning from residential treatment into the community, the SASS provider must communicate with the residential provider and ensure that a coordinated plan of care is available to the child and family at the time of discharge.

Provide staff to attend the DHS/ICG training, or meetings specific to intensive community-based care.

Maintain documentation of the support services rendered and provide that documentation to the DHS/ICG program office upon request.

DHS/ICG will only reimburse the SASS provider for intensive community based ICG services, whether those services are provided by SASS or provided through an alternate arrangement with another agency.

Note: Reimbursement rates for these services are forthcoming. There may be changes, subtractions or additions to this protocol during the implementation period.

APPENDIX CMH-4

DHS APPROVED PHARMACEUTICAL CLASSES FOR NON-MEDICAID COVERED CHILDREN

The Medicaid prior approval requirements and drug utilization requirements, such as maximum daily dose and refill-to-soon limitations, will apply to the pharmaceutical services provided under the SASS program.

Below are the general categories of DHS Approved Pharmaceuticals for Children during the approved SASS period. For a complete listing refer to the Web site at <http://www.dpallinois.com/cmh/preferred.html>.

- Anticholinergics
- Anti-convulsants
- Antipsychotics
- Atypical antipsychotics
- Beta-Adrenergic Blocking Agents
- Clonidine
- Novel antidepressants
- Psychostimulants and Strattera
- Tri-cyclic antidepressants
- Tenex
- MAO Inhibitors – monoamine oxidase inhibitors
- Sedative hypnotics (benzodiazepines, ambien, and newer)
- SSRIs - serotonin selective reuptake inhibitors

APPENDIX CMH-5

INSTRUCTIONS FOR REQUEST FOR EXTENDED SASS SERVICES FORM

Community SASS providers may request an extension for up to 30 additional days of services for their agency and other involved Community Mental Health Providers utilizing the process detailed below:

WHEN TO MAKE AN EXTENSION REQUEST

- When a child is hospitalized within the last 30 days of SASS services
- When a child re-presents to the CARES line AND meets acuity within 14 days after the last day of the most current service period. Children that present in crisis to the CARES line 15+ days post-SASS services would be treated as a new referral
- When a SASS agency feels extended service time is needed to stabilize a child in crisis. Requests should be made 14 days prior to the end the client's current eligibility period.

WHAT CONSTITUTES A COMPLETE EXTENSION REQUEST PACKET

- Correctly completed Request For Extended SASS Services form
- All CSPI's completed within the current service period
- A CSPI dated within 5 days of the request

**Once a complete packet is received a decision will be sent within 3 business days via fax.*

HOW TO REQUEST AN EXTENSION

To request an extension for your SASS provider and other Community Mental Health Providers please submit a typed or clearly written Extension Request Packet via fax to:

SASS Extension Review Team
C/O Child and Adolescent Network
Fax Number: 773-794-4881

HOW TO ENSURE THE REQUEST FORM IS FILLED OUT CORRECTLY

Answer all questions.

- The request will not be processed without a correct RIN or without answers to all questions. An incomplete request will be sent back without a decision and delays the process.

Be Specific.

- For services provided or services anticipated by the SASS agency and/or other Community Providers please indicate the services, (i.e. intensive family therapy, therapeutic stabilization, individual therapy), frequency (# of times per week) and duration period (days, weeks, months). Clearly explain why mental health services cannot be provided in your outpatient program or referred to another outpatient program. The more information provided, the clearer a decision can be made without additional requests for information.

Do NOT use short-cuts.

- Do not use abbreviations, initials for your agency, or DSM-IV codes. The diagnoses must be clearly written on the request or your request will be returned. If more than one Axis I diagnosis exists, the primary diagnosis should be listed first.

Type your request into the template or write legibly.

HOW TO ENSURE A TIMELY RESPONSE

- Answer all the questions. This cannot be stressed enough.
- Send in the request packet 14 days prior to the end of the client's current service eligibility period.
- Provide an accurate fax number for responses to be sent and if possible, assign a person within your agency who would be responsible for receiving and distributing the results to the correct person.

HOW TO RE-SUBMIT ADDITIONAL INFORMATION

- Resubmit the Extension Request Packet with the additional information that may not have been included in the original request as soon as possible to avoid any disruptions in eligibility.

REQUEST FOR EXTENDED SASS SERVICES

Date of request: _____

SASS AGENCY: _____

SASS AGENT: _____

LAN#: _____

SASS phone # _____

FAX#: _____

Clients Name: _____

RIN#: _____

Address: _____

DOB: _____

Age: _____

DCFS Ward: YES

NO

DCFS#: _____

Hospital Admission: _____

Hospital : _____

Date: _____

D/C (actual or anticipated from hospital): _____

DIAGNOSIS (please list by name):

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

MEDICATION:

Psychiatrist: _____

Phone: _____

REASON FOR EXTENSION (indicate SASS services already implemented and current at-risk behaviors. Include the duration and frequency of each service. Also, list the service provider for each service (i.e. name of community mental health provider)):

[illegible]

Child's Name _____

DESCRIBE ANY NON-SASS SERVICES CURRENTLY UTILIZED OR PLANNED

(indicate the agent providing the service, duration, frequency and/or date referred):

DESCRIBE THE CLIENT SERVICE PLAN FOR THE REQUESTED EXTENSION

(indicate the agent responsible for the provision of each service and timeframe necessary to complete the task.):

Community Mental Health Provider also requiring extension:

_____ LAN#: _____
_____ LAN#: _____
_____ LAN#: _____

EXTENSION REQUEST DECISION:

Granted _____ for _____ days

Comments: _____

Denied: _____

Reason: _____

Date SASS notified: _____

Date CARES notified: _____

FAX EXTENSION REQUEST FORM WITH CURRENT AND ALL CSPI

FORMS TO:

**SASS EXTENSION REVIEW TEAM
C/O CHILD AND ADOLESCENT NETWORK**

773-794-4881

APPENDIX CMH-6

TECHNICAL GUIDELINES FOR PAPER CLAIM PREPARATION FORM DPA 1443, PROVIDER INVOICE

Please follow these guidelines in the preparation of paper claims for imaging processing to ensure the most efficient processing by the department:

- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script or any font that has connecting characters.
- Claims should be typed or computer printed in capital letters. The character pitch must be 10-12 printed character per inch, the size of most standard pica or elite typewriters. Handwritten entries should be avoided.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as part of the original or as a result of photocopying a colored background, the print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold invoices or fasten attachment with staples.

Instructions for completion of this invoice follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required	= Entry always required.
Optional	= Entry optional – In some cases failure to include an entry will result in certain assumptions by the department and will preclude corrections of certain claiming errors by the department.
Conditionally Required	= Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.
Not Required	= Fields not applicable to the provision of provider services.

COMPLETION

ITEM EXPLANATION AND INSTRUCTIONS

Required	1. Provider Name - Enter the provider's name exactly as it appears on the Provider Information Sheet.
Required	2. Provider Number - Enter the Provider Number exactly as it appears on the Provider Information Sheet.
Required	3. Payee - Enter the one-digit code of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet.

<p>If no code is entered here, but the provider has designated more than one potential payee on the Provider Information Sheet, the claim will be rejected.</p>

Not Required	4. Role - leave blank.
Not Required	5. Emer - leave blank.
Not Required	6. Prior Approval – leave blank.
Optional	7. Provider Street - Enter the street address of the provider's primary office. If the address is entered, the department will, where possible, correct claims suspended due to provider eligibility errors. If the address is not entered, the department will not attempt corrections.

Conditionally Required	8. Facility & City Where Service Rendered - This entry is required when Place of Service Code in Field 23 (Service Sections) is 99 (off-site).
Optional	9. Provider City State ZIP - Enter city, state and ZIP code of provider. See Item 7 above.
Conditionally Required	10. Referring Practitioner Name - Enter the name of the provider who referred the patient for services.
Required	11. Recipient Name - Enter the patient's name exactly as it appears on the MediPlan Card, Temporary MediPlan Card, KidCare Card or Notice of Temporary KidCare Medical Benefits. Separate the components of the name (first, middle initial, last) in the proper sections of the name field.
Required	<p>12. Recipient No. - Enter the nine-digit number assigned to the individual as copied from the MediPlan Card, Temporary MediPlan Card, KidCare Card or Notice of Temporary KidCare Medical Benefits. Use no punctuation or spaces. Do <u>not</u> use the Case Identification Number.</p> <p>If the Temporary MediPlan Card does not contain the recipient number, enter the patient name and birthdate on the Provider Invoice and attach a copy of the Temporary MediPlan Card to the Provider Invoice. The department will review the claim and determine the correct recipient number. See "Mailing Instructions" in this Appendix when a copy of the Temporary MediPlan Card is attached.</p>
Optional	13. Birthdate - Enter the month, day and year of birth of the patient as shown on the MediPlan Card, Temporary MediPlan Card, KidCare Card or Notice of Temporary KidCare Medical Benefits. Use the MMDDYY format.
Not Required	14. H Kids - leave blank.
Not Required	15. Fam Plan - leave blank.
Not Required	16. ST/AB - leave blank.
Required	17. Primary Diagnosis - Enter the primary diagnosis which describes the condition primarily responsible for the patient's treatment.
Required	18. Primary Diag. Code - Enter the specific ICD-9-CM code for the primary diagnosis described in Item 17.

Required	19. Taxonomy – Enter the appropriate ten-digit HIPAA Provider Taxonomy Code. Refer to Chapter 300, Appendix 5.
Optional	20. Provider Reference - Enter up to 10 numbers or letters used in the provider's accounting system for identification. If this field is completed, the same data will appear on Form DPA 194-M-1, Remittance Advice, returned to the provider.
Conditionally Required	21. Ref Prac No - Enter the referring practitioner's state license number, Social Security number or AMA number.
Not Required	22. Secondary Diag Code – leave blank.
	23. Service Sections: Complete one service section for each item or service provided to the patient.
Required	Procedure Description/Drug Name, Form and Strength or Size - Enter the description of the service provided or item dispensed.
Required	Proc. Code/NDC - Enter the appropriate CPT, HCPCS or NDC.
Conditionally Required	Modifiers – Enter the appropriate two-byte modifiers for the service performed.
Required	Date of Service - Enter the date the service was provided. Use MMDDYY format.
Required	Cat. Serv. - Enter the appropriate two-digit code for the category of service provided. The applicable codes are: 34 – DMHDD Rehab Option Services 47 – DMHDD Targeted Case Management Services
Conditionally Required	Delete - When an error has been made that cannot be corrected, enter an "X" to delete the entire Service Section. Only "X" will be recognized as a valid character; all others will be ignored.
Required	P.O.S. - Enter the two-digit Place of Service Code from the following list: 11 – Office (Onsite) 99 – Other Place of Service (Offsite)

**Conditionally
Required**

Units/Quantity – Enter the appropriate number of units for the service.

Not Required

Modifying Units - leave blank.

**Conditionally
Required**

TPL Code – If the patient's MediPlan or KidCare Card contains a TPL code, the code is to be entered in this field. If there is no TPL resource shown on the card, no entry is required. If more than one third party made a payment for a particular service, the additional payment(s) are to be shown in Section 25.

When the date of service is the same as the “Spenddown Met” date on the DPA 2432 (Split Billing Transmittal) attach the DPA 2432 to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields.

If Form DPA 2432 shows a recipient liability greater than \$0.00, the invoice should be coded as follows:

TPL Code	906
TPL Status	01
TPL Amount	the actual recipient liability as shown on Form DPA 2432
TPL Date	the issue date on the bottom right corner of the DPA 2432. This is in MMDDYY format.

If Form DPA 2432 shows a recipient liability of \$0.00, the invoice should be coded as follows:

TPL Code	906
TPL Status	04
TPL Amount	0 00
TPL Date	the issue date on the bottom right corner of the DPA 2432. This is in MMDDYY format.

**Conditionally
Required**

Status – If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is blank.

The TPL Status Codes are:

01 – TPL Adjudicated – total payment shown: TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box.

02 – TPL Adjudicated – patient not covered: TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.

03 – TPL Adjudicated – services not covered: TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered.

04 – TPL Adjudicated – spenddown met: TPL Status Code 04 is to be entered when the patient's Form DPA 2432 shows \$0.00 liability.

05 – Patient not covered: TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force.

06 – Services not covered: TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.

07 – Third Party Adjudication Pending: TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.

10 – Deductible not met: TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

**Conditionally
Required**

TPL Amount – If there is no TPL code, no entry is required. Enter the amount of payment received from the third party health resource. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" box.

**Conditionally
Required**

TPL Date – A TPL date is required when any status code is shown. Use the date specified below for the applicable code:

Code	Date to be entered
01	Third Party Adjudication Date
02	Third Party Adjudication Date
03	Third Party Adjudication Date
04	Date from the DPA 2432
05	Date of Service
06	Date of Service
07	Date of Service
10	Third Party Adjudication Date

Required

Provider Charge - Enter the total charge for the service, not deducting any TPL.

Not Required

24. Optical Materials Only - leave entire section blank.

Sections 25 through 30 of the Provider Invoice are to be used: 1) to identify additional third party resources in instances where the patient has access to two or more resources and 2) to calculate total and net charges.

If a second third party resource was identified for one or more of the services billed in Service Sections 1 through 6 of the Provider Invoice, complete the TPL fields in accordance with the following instructions:

**Conditionally
Required**

25 Sect. # - If more than one third party made a payment for a particular service, enter the Service Section Number (1 through 6) in which that service is reported.

If a third party resource made a single payment for several services and did not specify the amount applicable to each, enter the number 0 (zero) in this field. When 0 is entered, the third party payment shown in section 25C will be applied to the total of all service sections on the Provider Invoice.

**Conditionally
Required**

25A TPL Code - Enter the appropriate TPL Resource Code referencing the source of payment (General Appendix 9). If the TPL Resource Codes are not appropriate enter 999 and enter the name of the payment source in section 35.

**Conditionally
Required**

25B Status - Enter the appropriate TPL Status Code. See the Status field in Item 23 above for correct coding of this field.

Conditionally Required	25C TPL Amount - Enter the amount of payment received from the third party resource.
Optional	25D TPL Date - Enter the date the claim was adjudicated by the third party resource. (See the Adjudication Date field in Item 23 above for correct coding of this field.)
Conditionally Required	26 Sect. # - (See 25 above).
Conditionally Required	26A TPL Code – (See 25A above).
Conditionally Required	26B Status – (See 25B above).
Conditionally Required	26C TPL Amount – (See 25C above)
Conditionally Required	26D TPL Date – (See 25D above).
Conditionally Required	27 Sect. # - (See 25 above).
Conditionally Required	27A TPL Code – (See 25A above).
Conditionally Required	27B Status – (See 25B above).
Conditionally Required	27C TPL Amount – (See 25C above)
Conditionally Required	27D TPL Date – (See 25D above).

Claim Summary Fields: The three claim summary fields must be completed on all Provider Invoices. These fields are Total Charge, Total Deductions and Net Charge. They are located at the bottom far right of the form.

Required	28. Tot Charge - Enter the sum of all charges submitted on the Provider Invoice in Service Section 1 through 6.
Required	29. Tot Deductions - Enter the sum of all payments received from other sources. If no payment was received, enter three zeroes (000).

Required	30. Net Charges - Enter the difference between Total Charge and Total Deductions.
Required	31. # Sects - Enter the total number of service sections completed correctly in the top part of the form. This entry must be at least one and no more than 6. Do not count any sections which were deleted because of errors.
Not Required	32. Original DCN - leave blank.
Not Required	33. Sect. – leave blank.
Not Required	34. Bill Type – leave blank.
Conditionally Required	35. Uncoded TPL Name - Enter the name of the third party health resource. The name must be entered if TPL code 999 is used.
Required	36-37 Provider Certification, Signature and Date - After reading the certification statement, the provider must sign the completed form. The signature must be handwritten in black or dark blue ink. A stamped or facsimile signature is not acceptable. Unsigned Provider Invoices will not be accepted by the department and will be returned to the provider when possible. The signature date is to be entered.

MAILING INSTRUCTIONS

The Provider Invoice is a two-part form. The provider is to submit the original to the department as indicated below. The copy of the claim is to be retained by the provider.

The pin-feed guide strip should be detached from the sides of continuous feed forms.

Routine claims are to be mailed to the department in pre-addressed mailing envelopes, Form DPA 1444, Provider Invoice Envelope, provided by the department.

Non-routine claims are to be mailed to the department in pre-addressed mailing envelope, Form DPA 2248, Special Handling Envelope, which is provided by the department for this purpose. A non-routine claim is one to which one or more of the following documents are attached:

- Form DPA 1411, Temporary MediPlan Card
- Any other document



PROVIDER INVOICE
ILLINOIS DEPARTMENT OF PUBLIC AID
USE CAPITAL LETTERS ONLY

PRV

IDPA USE ONLY

1. PROVIDER NAME (FIRST, LAST)			2. PROVIDER NUMBER		3. PAYEE	4. ROLE	5. EMER	6. PRIOR APPROVAL	
<input type="text"/>			<input type="text"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
7. PROVIDER STREET			8. FACILITY & CITY WHERE SERVICE RENDERED						
<input type="text"/>			<input type="text"/>						
9. PROVIDER CITY		STATE	ZIP	10. REFERRING PRACTITIONER NAME (FIRST, LAST)					
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>					
11. RECIPIENT NAME (FIRST, MI, LAST)			12. RECIPIENT NUMBER		13. BIRTHDATE		14. H. KIDS	15. FAM. PLAN	16. ST/AB
<input type="text"/>			<input type="text"/>		<input type="text"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
17. PRIMARY DIAGNOSIS DESCRIPTION									18. PRIMARY DIAG. CODE
<input type="text"/>									<input type="text"/>
19. TAXONOMY		20. PROVIDER REFERENCE			21. REF. PRAC. NO.		22. SECONDARY DIAG. CODE		
<input type="text"/>		<input type="text"/>			<input type="text"/>		<input type="text"/>		

23. SERVICE SECTIONS

1	PROCEDURE DESCRIPTION / DRUG NAME, FORM, AND STRENGTH OR SIZE				PROC. CODE/NDC		MODIFIERS		DATE OF SERVICE		CAT. SERV.	DELETE
	<input type="text"/>				<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>
	P.O.S.	UNITS / QUANTITY	MODIFYING UNITS	TPL CODE	STATUS	TPL AMOUNT		TPL DATE		PROVIDER CHARGE		
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>		<input type="text"/>		
2	PROCEDURE DESCRIPTION / DRUG NAME, FORM, AND STRENGTH OR SIZE				PROC. CODE/NDC		MODIFIERS		DATE OF SERVICE		CAT. SERV.	DELETE
	<input type="text"/>				<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>
	P.O.S.	UNITS / QUANTITY	MODIFYING UNITS	TPL CODE	STATUS	TPL AMOUNT		TPL DATE		PROVIDER CHARGE		
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>		<input type="text"/>		
3	PROCEDURE DESCRIPTION / DRUG NAME, FORM, AND STRENGTH OR SIZE				PROC. CODE/NDC		MODIFIERS		DATE OF SERVICE		CAT. SERV.	DELETE
	<input type="text"/>				<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>
	P.O.S.	UNITS / QUANTITY	MODIFYING UNITS	TPL CODE	STATUS	TPL AMOUNT		TPL DATE		PROVIDER CHARGE		
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>		<input type="text"/>		
4	PROCEDURE DESCRIPTION / DRUG NAME, FORM, AND STRENGTH OR SIZE				PROC. CODE/NDC		MODIFIERS		DATE OF SERVICE		CAT. SERV.	DELETE
	<input type="text"/>				<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>
	P.O.S.	UNITS / QUANTITY	MODIFYING UNITS	TPL CODE	STATUS	TPL AMOUNT		TPL DATE		PROVIDER CHARGE		
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>		<input type="text"/>		
5	PROCEDURE DESCRIPTION / DRUG NAME, FORM, AND STRENGTH OR SIZE				PROC. CODE/NDC		MODIFIERS		DATE OF SERVICE		CAT. SERV.	DELETE
	<input type="text"/>				<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>
	P.O.S.	UNITS / QUANTITY	MODIFYING UNITS	TPL CODE	STATUS	TPL AMOUNT		TPL DATE		PROVIDER CHARGE		
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>		<input type="text"/>		
6	PROCEDURE DESCRIPTION / DRUG NAME, FORM, AND STRENGTH OR SIZE				PROC. CODE/NDC		MODIFIERS		DATE OF SERVICE		CAT. SERV.	DELETE
	<input type="text"/>				<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>
	P.O.S.	UNITS / QUANTITY	MODIFYING UNITS	TPL CODE	STATUS	TPL AMOUNT		TPL DATE		PROVIDER CHARGE		
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>		<input type="text"/>		

24. OPTICAL MATERIALS ONLY												
24A. RX TYPE		24B. LENS TYPE		24C. CORRECTION CHANGE		25. SECT. #	25A. TPL CODE	25B. STATUS	25C. TPL AMOUNT		25D. TPL DATE	28. TOT. CHARGE
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>
24D. RIGHT SPHERE		24E. RIGHT CYLINDER		24F. RIGHT PRISM		26. SECT. #	26A. TPL CODE	26B. STATUS	26C. TPL AMOUNT		26D. TPL DATE	29. TOT. DEDUCTIONS
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>
24G. LEFT SPHERE		24H. LEFT CYLINDER		24I. LEFT PRISM		27. SECT. #	27A. TPL CODE	27B. STATUS	27C. TPL AMOUNT		27D. TPL DATE	30. NET CHARGES
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>

31. #SECT	32. ORIGINAL DCN	33. SECT	34. BILL TYPE	35. UNCODED TPL NAME
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

I AGREE TO COMPLY WITH THE REQUIREMENTS IN THE CERTIFICATION WHICH APPEARS ON THE REVERSE SIDE AND IS PART OF THIS BILL.


<input type="text"/>	<input type="text"/>
36. PROVIDER SIGNATURE (DO NOT USE RUBBER STAMP)	37. DATE




APPENDIX CMH-7

EXPLANATION OF INFORMATION ON PROVIDER INFORMATION SHEET

The Provider Information Sheet is produced when a provider is enrolled in the department's Medical Programs. It will also be generated when there is a change or update to the provider record. This sheet will then be mailed to the provider and will serve as a record of all the data that appears on the Provider Data Base.

If, after review, the provider notes that the Provider Information Sheet does not reflect accurate data, the provider is to line out the incorrect information, note the correct information, sign and date the signature on the document and return it to the Provider Participation Unit in Springfield, Illinois. (See Topic CMH-205.2 for instructions.) If all the information noted on the sheet is correct, the provider is to keep the document and reference it when completing any department forms.

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet is attached as Appendix CMH-7a. The item numbers that correspond to the explanations below appear in small circles  on the sample form.

FIELD	EXPLANATION
 Provider Key	This number uniquely identifies the provider and is to be used as the provider number when billing charges to the department.
 Provider Name And Location	This area contains the Name and Address of the provider as carried in the department's records. The three-digit County code identifies the county in which the provider maintains his primary office location. It is also used to identify a state if the provider's primary office location is outside of Illinois. The Telephone Number is the primary telephone number of the provider's primary office.
 Enrollment Specifics	<p>This area contains basic information concerning the provider's enrollment with the department.</p> <p>Provider Type is a three-digit code and corresponding narrative which indicates the provider's classification.</p>

Organization Type is a two-digit code and corresponding narrative indicating the legal structure of the environment in which the provider primarily performs services. The possible codes are:

- 01 = Individual Practice
- 02 = Partnership
- 03 = Corporation
- 04 = Group Practice

Enrollment Status is a one-digit code and corresponding narrative which indicates whether or not the provider is currently an active participant in the department's Medical Programs. The possible codes are:

- B = Active
- I = Inactive
- N = Non Participating

Disregard the term MOCST if it appears in this term.

Immediately following the enrollment status indicator are the **Begin** date indicating when the provider was most recently enrolled in department's Medical Programs and the **End** date indicating the end of the provider's most current enrollment period. If the provider is still actively enrolled, the word "ACTIVE" will appear in the **End** date field.

Exception Indicator may contain a one-digit code and corresponding narrative indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are:

- A = Exception Requested by Audits
- C = Citation to Discover Assets
- G = Garnishment
- S = Exception Requested by Provider Participation Unit
- T = Tax Levy

If this item is blank, the provider has no exception.

Immediately following the **Exception Indicator** are the **Begin** date indicating the first date when the provider's claims are to be manually reviewed and the **End** date indicating the last date the provider's claims are to be manually reviewed. If the provider has no exception, the date fields will be blank.

AGR (Agreement) indicates whether the provider has a form DPA 1413 (Provider Agreement) on file. If the value of the field is yes, the provider is eligible to submit claims electronically.

- 4 **Certification/
License Number** This unique number identifies the license issued by a state agency authorizing a provider to practice or conduct business. This entry is followed by the **Ending** date indicating when the license will expire.
- 5 **S.S.#** This field is the provider's Social Security number or FEIN.
- 6 **Categories of
Service** This area identifies special licensure information and the types of service a provider is enrolled to provide.
- Eligibility Category of Service** contains one or more three-digit codes and corresponding narrative indicating the types of service a provider is authorized to render to patients covered under the department's Medical Programs. The codes are:
034 – DMHDD Rehab Option Services
047 – DMHDD Targeted Case Management Services
- Each entry is followed by the date that the provider was approved to render services for each category listed.
- 7 **Payee
Information** This area records the name and address of any persons or entities authorized to receive payments on behalf of the provider. Each potential payee is assigned a single-digit **Payee Code**, which is to be used on the claim form to designate the payee to whom the warrant is to be paid.
- If no payee number is designated on a claim form, but multiple payees are shown on the Provider Information Sheet, the claim will be rejected.
- Payee ID Number** is a sixteen-digit identification number assigned to each payee to whom warrants may be issued. A portion of this number is used for tax reporting purposes, therefore no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider.
- The **Medicare/PIN** or the **DMERC #** is the number assigned to the payee by the Medicare Carrier to crossover Medicare billable services. The **PIN** is the number assigned by Medicare to a provider within a group practice, if applicable.
- 8 **Signature** The provider is required to affix an original signature when submitting changes to the Department of Public Aid.

APPENDIX CMH-7a

Reduced Facsimile of Provider Information Sheet

2

MEDICAID SYSTEM (MMIS)
PROVIDER SUBSYSTEM
REPORT ID: A2741KD1
SEQUENCE: PROVIDER TYPE
PROVIDER NAME

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
PROVIDER INFORMATION SHEET

3

RUN DATE: 11/02/99
RUN TIME: 11:47:06
MAINT DATE: 11/02/99
PAGE: 84

1

--PROVIDER KEY--
000011111001

PROVIDER NAME AND ADDRESS
COMMUNITY MENTAL HEALTH AGENCY
1421 MY STREET
ANYTOWN, IL 62000

PROVIDER TYPE: 036 - MENTAL HEALTH SERVICES PROVIDERS
ORGANIZATION TYPE: 03 - CORPORATION
ENROLLMENT STATUS B - ACTIV NOCST BEGIN 11/15/86 END ACTIVE
EXCEPTION INDICATOR - NO EXCEPT BEGIN END
AGR: YES BILL: NONE

PROVIDER GENDER:
COUNTY 089-SCOTT
TELEPHONE NUMBER 217-742-4567

CERTIFIC/LICENSE NUM - 000011111 ENDING 03/31/02

D.E.A.#:
RE-ENROLLMENT INDICATOR: N DATE: 11/15/86

LAST TRANSACTION ADD AS OF 04/21/97

UPIN#:
SS #: 00000000
CLIA#:

4

5

6

HEALTHY KIDS/HEALTHY MOMS INFORMATION: BEGIN DATE: / /

COS	ELIGIBILITY CATEGORY OF SERVICE	ELIG BEG DATE	COS	ELIGIBILITY CATEGORY OF SERVICE	ELIG BEG DATE	TERMINATION REASON
034	DMHDD Rehab Option Services					
047	DMHDD Targeted Case Management Services					

7

PAYEE
CODE 1
PAYEE NAME
PAYEE STREET 1421 MY STREET
PAYEE CITY ANYTOWN
ST ZIP IL 62000
PAYEE ID NUMBER 001010101-6200-01
DMERC#
EFF DATE 11/15/86
VENDOR ID: 01
DBA:
MEDICARE/PIN: 999999

8

***** PLEASE NOTE: *****
* ORIGINAL SIGNATURE OF PROVIDER REQUIRED WHEN SUBMITTING CHANGES VIA THIS FORM: DATE _____ X _____

APPENDIX CMH-8

DEPARTMENTS CONTACT INFORMATION AND OTHER RESOURCES

CMH Specific Resources

LAN Map	http://www.dpaillinois.com/cmh/lanmap1.htm
Service definition and activity crosswalk	http://www.dpaillinois.com/cmh/132crosswalk.html
59 IL Administrative Code 132	http://www.dhs.state.il.us/revisedRule132/
Medicaid Enrollment	http://www.dpaillinois.com/medical/apply
Rule 132 Question and Answer	http://www.dhs.state.il.us/revisedRule132/dhs_rr132_revisedRule132tqa.asp
EMTALA	http://www.emtala.com/

DCFS Specific Resources

59 IL Administrative Code 135	http://163.191.134.21/docs/rules/
Consolidated Financial Report	www.state.il.us/dcfs/costrpt/cstmain.html
CSPI Manual and Summary Form	http://www.dcfsoutcomesnu.com
DCFS CFS-600-3, Consent Release of Info.	http://www.state.il.us/dcfs/docs/cfs600_3.htm
DCFS CFS 431A, Consent for Psych. Meds	http://www.state.il.us/DCFS/docs/CFS43-1A.pdf

DHS Specific Resources

USARF	http://www.dhs.state.il.us/mhdd/mh/pdf/polpdf/usarf_ca.pdf
Applic. by Adult for Admission of Minor	http://www.dhs.state.il.us/mhdd/mh/pdf/polpdf/usarf_ad.pdf
DHS Billing Manual	http://www.dhs.state.il.us/mhdd/mh/repCommServices/
MHDD Mental Health Code	http://www.legis.state.il.us/commission/jcar/admincode/059/059parts.html

DPA Specific Resources

DPA Provider Enrollment Info	http://www.dpaillinois.com/enrollment/
Chapter 100	http://www.dpaillinois.com/handbooks/chapter100.html
Chapter 200	http://www.dpaillinois.com/handbooks/chapter200.html
Chapter 300	http://www.dpaillinois.com/handbooks/chapter300.html
89 IL Administrative Code 140	http://www.dpaillinois.com/lawsrules/index.html

Inquiries regarding the SASS Program:

Department of Human Services
Director of Contract Management/Child and Adolescent Services
773-794-4872

Department of Children and Family Services
SASS Manager
312-814-6805

Department of Public Aid
SASS@idpa.state.il.us

Inquiries regarding SASS billing issues:

Department of Public Aid
Bureau of Comprehensive Health Services
877-782-5565
SASS@idpa.state.il.us

Inquiries regarding pharmacy billing issues:

Department of Public Aid
Bureau of Pharmacy Services
877-782-5565

CARES CRISIS LINE INTAKE

Crisis LAN # _____ HSI# _____

Date _____ Time _____ CL Wkr _____ Home LAN# _____ HSI# _____

Client Information: Ward [] Non-Ward [] Current RIN : _____ (must verify)

Client Name: _____ DOB: _____ Age _____

Ward [] Non-Ward [] Gender: M F Race: _____ Language: _____

SSN / DCFS ID#: _____ Caretaker Aware of Referral? Y N U

Parent/Guardian: _____ Telephone: ____/____-_____

Address: _____ City _____ Zip _____ County _____

Private Insurance [] Medicaid HMO []

Referral Information:

Caller Name: _____ Agency: _____

Address: _____ Telephone: ____/____-_____

City: _____ Zip: _____ County: _____

If client is not at home, specify crisis location: _____

Address: _____ City _____ Zip _____ County _____

Contact: _____ Telephone: ____/____-_____

Presenting Problem: (include whether FP gave 14 day notice):

YES Circle Pts	ACUITY ASSESSMENT
	911 / POLICE ASSISTANCE
	At this moment, is the youth's behavior likely to cause immediate and significant harm to self, others, or property? If yes, stop assessment. Call police NOW.
	Does he/she currently have a weapon? If yes, stop assessment. Call police NOW.
	HISTORY OF PSYCHIATRIC TREATMENT (No points.)
	Has the youth been admitted to a psychiatric hospital before? [Y] [N] When: ____/____/____
	Have psychotropic medications been prescribed for the youth in the past? [Y] [N] Are psychotropic medications currently prescribed for the youth? [Y] [N] Do you know their names or what they are prescribed for? _____
	Is the youth refusing to take the medication? [Y] [N]
	HOMELESSNESS
	Is the youth's living situation currently in jeopardy?
	RISK BEHAVIORS
	Is youth running away?
	Is youth using alcohol?
	Is youth using drugs?
	Is the youth involved in prostitution?
	Is he/she involved with a gang?
	SELF HARM / SUICIDE
	Has the youth spoken about harming him/her self or said he/she wished he/she were dead? (last 48 hrs.)
	(If previous answer is yes,) Has the youth described or acted on a specific plan for hurting themselves? (last 48 hrs.) What did they say?
	(If youth has a plan of self harm,) Is there a way he/she could follow through on that plan? (For example, if youth said they would overdose, ask if there are medications in the home. If they said they wanted to shoot themselves, ask if there is a gun in the home and if so, tell the caller to secure it!)
	Has the youth made any current attempts to harm self? (last 48 hours) (Include any act that could be considered deliberate self harm, whether superficial, like swallowing "a few" aspirins, cutting themselves superficially or banging their head against the wall, or more serious, like cutting themselves, putting their fist through glass or slashing themselves.) What did they do?
	Has he/she tried to harm themselves in the past (6 months):
	HARM TO OTHERS / AGGRESSIVE / IMPULSIVE
	Has the youth severely hurt someone? (last 48 hrs.) (A fist fight may not qualify, but will if significant injury is caused. Use of weapon, choking, biting someone hard enough to break the skin does qualify.)
	Has he/she said he/she wants or intends to severely harm someone? (last 48 hrs.) (Follow same parameters as above.)
	Does he/she have a history of harming others? (last 6 months)

	Has the youth acted aggressively, towards others or animals intimidated others or destroyed property ,set fires? (last 48 hrs.) Describe specific aggressive actions?
	Has the youth been sexually aggressive toward anyone? (last 48 hrs.) This would include exhibitionism, fondling young children, or initiating any other non-consensual sexual behavior. (Wards only refer to S.A.C.Y. if total score < 60 pts.)
	Has the youth engaged in increased sexual activity or dangerous sexual activity (Has youth suddenly displayed sexual or promiscuous behaviors that are new for age and level of maturity) (last 48 hrs.)
	BIZARRE / PSYCHOTIC
	Are they saying or doing things that don't make sense to you, like laughing for no reason, standing in an odd posture or not speaking for a significant length of time? Or is he/she inappropriately talking to him/herself?
	Does he/ she think people are after him/her or are plotting against him/her? This may be indicated by behavior such as hiding, cowering in a corner, unusual suspiciousness,etc.
	Is he/she hearing voices or seeing things that are not really there?
	Note: The youth having fallen asleep does not mean SASS should be cancelled. He/she has likely worked him or herself into a state of exhaustion and will awaken in the same aggressive/suicidal/impulsive state
	A score of 60 or more requires that SASS assess the youth immediately.
	<i>Scoring Key:</i> Answer yes circling corresponding point values. Total all points. A score of 60 or greater requires immediate SASS assessment. Once score reaches 60, a higher score does not necessarily reflect greater acuity. If total is less than 60 pts and client is a ward refer to S.O.C. If client is not a ward, refer to community-based services. LPHA can override a score between 45 and 60 pts, with signature and written justification.

RIN Search Results:

Database Access: Start: _____ am/pm	End: _____ am/pm
Child in DHS Name File? Y N	Multiple RINs Found? Y N
For Multiple RINs was medical RIN found? Y N	Current RIN status (RST): Inactive Active
Current RIN : _____	New [] or Reassigned []

SASS Referral Information

Agency Name: _____	Time CARES' Called SASS _____
Tel# Called: ____/____-_____	Initial Contact: _____
SASS Worker Responding: _____	Time of SAS response _____
Other contacting data: _____	Time of SASS arrival _____
Three-Way : _____	

Wards Only

DCFS ID#: _____	
Area Office: _____	Agency: _____
DCFS Team #: _____	R.S.F.#: _____
DCFS C.W.: _____	POS C.W.: _____
Address: _____	Address: _____
City: _____ ZIP: _____	City: _____ ZIP: _____
Tel#: ____/____-_____	Tel#: ____/____-_____

Acuity Score

Low Acuity Score less than 45 pts and SASS was not called. []
Acuity Score between 45 - 60 and SASS was called. [] Clinician /LPHA must sign and justify. Acuity Score between 45 - 60 and SASS was not called. [] Clinician /LPHA must sign and justify. Justification: _____ _____
Clinician / LPHA signature: _____

IDPA Screen Complete []

Client Presented at Hospital: C.L. Worker Taking call:

On ____/____/____, CARES received a call from _____ (caller's name,) of _____ Hospital, provider number _____, stating that client presented at that hospital. Note: Enter H.S.I. screen!

Referral to Additional SASS Agency C. L. Worker Taking call:

On ____/____/____, CARES received call from SASS Agency _____, who requested case be referred to _____ SASS Agency, LAN # _____. Referral was made on IDPA Screen: []
--